Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting February 2, 2022

February 2, 2022

Introductions

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

Objectives

- Introductions
- Overview of the Workgroup Plan
- Discuss Federal Requirements around the Health Home Program.
- Discuss OIG Final Report

Overview of the Timeline

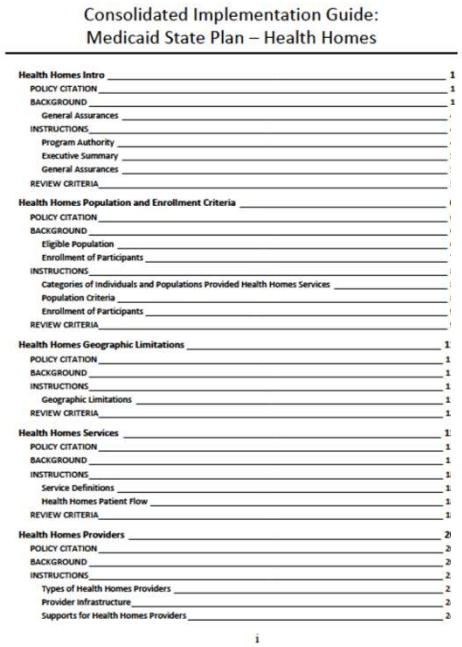
HUMAN SERVICES

Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities. This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • Iowa Code (draft)
February 16, 2022	Level Setting • Integrated Health Home SPA
March 2, 2022	Review of the Survey and Listening Sessions.
March 16, 2022	Review of Last meeting's feedback Health Home Providers Provider Standards • How does the Health Home Meet?
March 30th, 2022	Review of Last meeting's feedback Provider Standards • How does the MCO/IM Support and oversee?
April 13, 2022	Review of Last meeting's feedback Payment Methodologies Member Qualifications
April 27, 2022	Review of Last meeting's feedback Health Home Services • Comprehensive Care Management • Care Coordination • Health Promotion
May 11, 2022	Review of Last meeting's feedback Health Home Services
	• Comprehensive Transitional Care • Individual and Family Support • Referral to community and Social Support Services
May 25, 2022	Review of Last meeting's feedback Quality Improvement • Learning Collaborative contents • IHH Internal QI/QA structure
June 8. 2022	Review of Last meeting's feedback Quality Improvement • IHH Internal QI/QA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today



Consolidated Implementation Guide:
Medicaid State Plan – Health Homes

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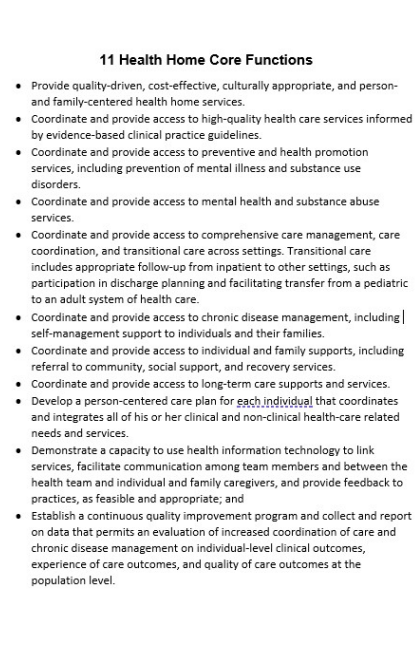
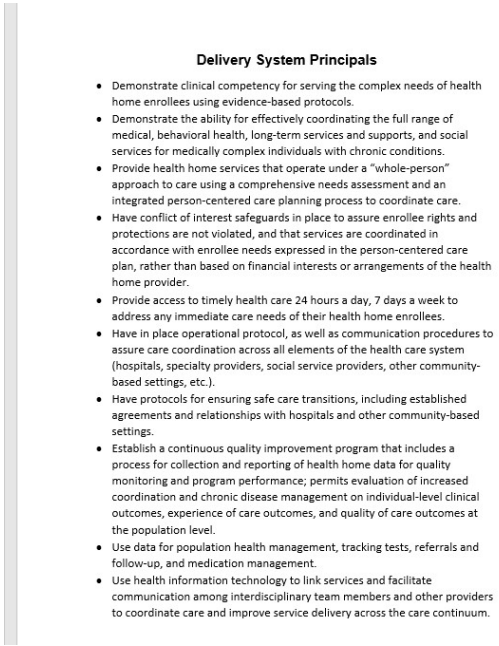


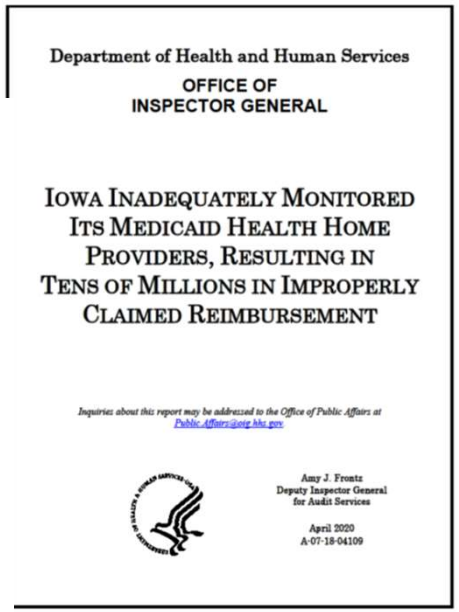
11 Health Home Core Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.



Delivery System Principals

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).
- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

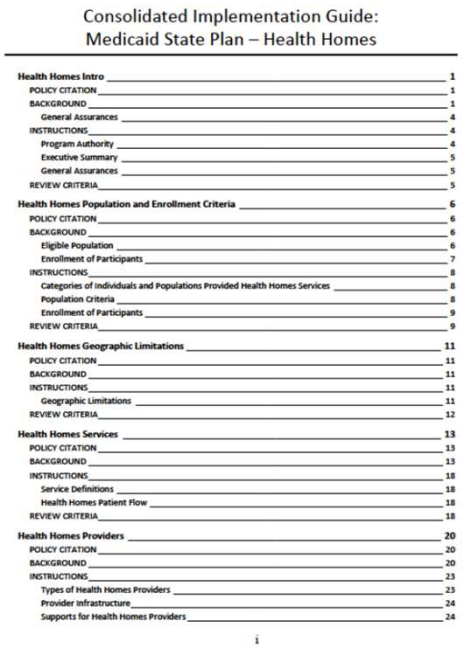
IOWA INADEQUATELY MONITORED ITS MEDICAID HEALTH HOME PROVIDERS, RESULTING IN TENS OF MILLIONS IN IMPROPERLY CLAIMED REIMBURSEMENT

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Amy J. Frontz
Deputy Inspector General
for Audit Services

April 2020
A-07-18-04109

IG_HealthHomes_Consolidated



Consolidated Implementation Guide:
Medicaid State Plan – Health Homes

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Health Homes Intro

- **Program Authority:** Name of the Health Homes Program
- **Executive Summary:** The State is required to submit an executive summary of their Health Homes program including the goals and objectives of the program, the population served, provider requirements, services provided, and the service delivery model used in the program.
- **Provide General Assurances:** The State must check the general assurances.

What are the General Assurances?

- Eligible members will be given a free choice of Health Homes providers.
- Dually-eligible for Medicare and Medicaid eligible members must be enrolled if they choose.
- Health Homes services will be made available to all individuals who meet the eligibility criteria regardless of age.
- Participating hospitals will work with Health Homes to make referrals and to provide timely medical information on potential or current Health Homes members who have received medical treatment at the hospital, whether through emergency room or inpatient admissions.
- Health Homes providers must develop a working relationship with hospitals to assure that information is shared and communicated efficiently to all community providers.
- There will be no duplication of services and payment for similar services provided under other Medicaid authorities.
- States with one or more existing care management program must assure that there will be no duplication of services and no duplicate payment for the same services as those provided through the Health Homes program.

Population and Enrollment Criteria

Eligible Population

- States electing the Health Homes benefit must cover, at a minimum, all Categorically Needy eligible individuals who have the chronic conditions specified/selected in their SPA.
- The target population cannot be based on the age of the beneficiary and dual eligible cannot be specifically excluded from the target population.
- States may tailor their standards or specifications for Health Homes to meet the unique needs of children and adult populations.
- States may tailor their standards or specifications for Health Homes to meet the unique needs of children and adult populations.
  - An individual who is eligible for assistance under the state plan or under a waiver of such plan and has at least 2 chronic conditions; 1 chronic condition and is at risk of having a second chronic condition; or
  - 1 serious and persistent mental health condition, per the state's defined chronic condition eligibility criteria.
- States may elect to have a medical necessity test that makes Health Homes services available only to individuals with higher severity of chronic or mental health conditions.

General Enrollment Criteria

- The state, health care providers and hospitals may refer individuals
- Individuals may choose among the qualified Health Homes providers and may change or disenroll at any time.
- Individuals may only receive Health Homes services from one provider in a given period of time.
- Enrollment must be documented by the provider.
- The state will need to make sure that the Health Homes providers maintain documentation indicating that the individual has, in fact, enrolled and given consent to participate in the Health Homes program. This documentation should, at a minimum, indicate that the individual has received required information explaining the Health Homes program and the date that the individual enrolled in the program. Documentation of the individual's enrollment, and of any subsequent disenrollment, must be maintained in the enrollee's health record by the Health Homes Provider.
- The Health Homes provider should notify the state of the disenrollment and cease Health Homes billing for the disenrolled person.

Categories of Individuals and Populations

- Must cover all: Medicaid Programs | Iowa Department of Human Services
  - Categorically needy eligibility groups
  - Dual Eligibles
- If “One serious and persistent mental health condition” was selected as a target population:
  - Specify the criteria for identifying the serious and persistent mental health condition and briefly describe why it is considered serious and persistent and how Health Homes services will help improve overall care and reduce costs for these individuals.

Population Criteria

- Select one or more of the following three options:
  - Individuals with two or more chronic conditions,
  - Individuals with one chronic condition with the risk of developing another chronic condition,
  - **Individuals with one serious and persistent mental health condition.**
- If “One serious and persistent mental health condition” was selected as a target population:
  - Specify the criteria for identifying the serious and persistent mental health condition and briefly describe why it is considered serious and persistent and how Health Homes services will help improve overall care and reduce costs for these individuals.

Enrollment of Participants

- **Opt-in to Health Homes provider**
  - If this is selected, describe the process used in the text box provided.
- Referral and assignment to Health Homes provider with opt-out
  - If this is selected, describe the process used in the text box provided.
  - Check the assurance that the state will clearly communicate the individual's right to opt out or to change providers.
  - Upload a copy of any letters or other communications used to information individuals of their rights. At least one document must be uploaded, and more than one may be uploaded.
- Other
  - If this is selected, describe the process used in the text box provided.

Geographic Limitations

Geographic Limitations

Select one of the 3 options:

- **Health Homes services will be available statewide.**
- Health Homes services will be limited to the following geographic areas.
  - County
  - Region
  - City
- Health Homes services will be provided in a geographic phased-in approach.

Health Home Services

General Statements

- Must be able to provide all Health Home Services
- Members receive comprehensive, coordinated, and high-quality care throughout their lifespan, using a person-centered care process.
- Use health information technology in delivering coordinated care and meeting the purpose of the Health Homes benefit.
- Focused on activities that maintain wellness and improve overall health quality through coordinated care for all the individual's needs.
- Encourage the member to be educated about their chronic condition and to take control of their own wellbeing by partnering with their providers, health coaches, and others to get the outcomes they want for themselves.
- Key to the success of care coordination is the ability to engage the individual and build trust and support on an ongoing basis. We want to emphasize the importance of engaging the Health Homes members to achieve successful health outcomes. Health Homes team members may need to meet with the Health Homes enrollee multiple times in person in their home or in a community setting to build trust and establish a relationship.

Comprehensive Care Management

- Conducting outreach and engagement activities to gather information from the member, the member's support, and other primary and specialty care providers.

- Completing a comprehensive needs assessment.
  - The comprehensive assessment includes current and historical information provided by the enrollee, as well as information received from available health care records, input received through consultation with other health care providers and the member's support, and assessments performed by telemedicine or other information technology medium as appropriate. It also includes a physical examination, behavioral assessment, medication reconciliation, functional limitations, screenings as deemed appropriate, assessment of clinical and social support needs, and any "at risk" concerns. Information received from the comprehensive assessment then serves as the basis for the person-centered care plan.

  - The comprehensive needs assessment should be conducted at least every 12 months (or more frequently as needed), when the individual's needs or circumstances change significantly, or at the request of the enrollee or the enrollee's support member.

Comprehensive Care Management Cont.

- Developing a comprehensive person-centered care plan.
  - The person-centered care plan serves as the basis for the coordination of care among Health Homes providers. The Health Homes interdisciplinary team develops a person-centered care plan jointly with each Health Homes member consistent with §441.725.
  - The care plan is to be developed by a licensed health care professional for the Health Homes program, in collaboration with the Health Homes member, and individuals chosen by the member to serve as contributors to the planning process.
  - In addition, it must include input from an interdisciplinary team and other key providers (the individual's primary care physician, nurse care manager, behavioral health providers, social work professionals and other providers as appropriate) to assess and evaluate the health, behavioral health, and long-term services and supports, as well as the social needs of the participant.
  - Requirements for the Person-centered care plan are consistent with HCBS final Rule

Care Coordination

- Implementing the person-centered care plan.
- Continuous monitoring of progress towards goals identified in the person-centered care plan through face-to-face and collateral contacts with member, member's support, and primary and specialty care providers.
- Supporting the member's adherence to prescribed treatment regimens and wellness activities.
- Participating in hospital discharge processes to support the member's transition to a non-hospital setting.
- Communicating and consulting with other providers and the member and member's support, as appropriate.
- Facilitating regularly scheduled interdisciplinary team meetings to review care plans and assess progress.

Health Promotion

- Promoting member's education of their chronic condition.
- Teaching self-management skills.
- Conducting medication reviews and regimen compliance.
- Promoting wellness and prevention programs by assisting Health Homes members with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on member's needs and preferences.

Comprehensive Transitional Care

- Establishing relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long-term services and supports providers to promote a smooth transition if the enrollee is moving between levels of care and back into the community.
- This includes prompt notification and ongoing communication of member's admission and/or discharge to and from an emergency room, inpatient residential, rehabilitative or other treatment settings.
- If applicable, this relationship should also include active participation in discharge planning with the hospital or other treatment settings to ensure consistency in meeting the goals of the member's person-centered care plan;
- Communicating and providing education to the member, the member's support, and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning.
- Developing a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:
  - Receipt of a summary of care record from the discharging entity.
  - Medication reconciliation
  - Reevaluation of the care plan to include and provide access to needed community support services.
  - A plan to ensure timely scheduled appointments.

Individual and Family Support

- Providing education and guidance in support of self-advocacy.
- Providing caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
- Identifying resources to assist individuals and family support members in acquiring, retaining, and improving self-help, socialization and adaptive skills.
- Providing information and assistance in accessing services such as: self-help services, peer support services; and respite services.

Referral to Community and Social Support

- Providing referral and information assistance to individuals in obtaining community-based resources and social support services;
- Identifying resources to reduce barriers to help individuals in achieving their highest level of function and independence.
- Monitoring and follow up with referral sources, member, and member's support, to ensure appointments and other activities, including employment and other social community integration activities, were established and members were engaged in services.

Health Homes Service Definitions

Service Definitions

- Clearly explain how it will operate under a whole-person approach to care.
- Describe how the approach to care will be person-centered, taking into account each person's unique needs, culture, values and preferences, with the person involved in the care plan.
- Describe the comprehensive team-based approach to care provided by a cohesive team, including:
  - The roles and responsibilities of team members;
  - How primary and behavioral health will be integrated;
  - Describe how the team will coordinate care across all elements of the health care system and provide the linkages to medical and social resources in the community.

Describe how health information technology will be used to link each service in a comprehensive approach across the continuum of care.

Describe the scope of services, by provider types.

- Select one or more provider types that can provide the Health Homes service and enter a description of each provider type selected.
- If "Other" is selected, enter the provider type in addition to a description.
- More than one "Other" provider type may be entered

Health Homes Providers

Types of Health Homes Providers

- Designated Providers
- **Teams of Health Care Professionals**
- Health Teams.

For each specific kind of professional/provider selected, describe the qualifications and standards that must be met in order for that kind of professional/provider to participate in the Health Homes program, including professional degrees, certifications and licenses to practice in the state and the capability to provide all of the required Health Homes services.

Provider Infrastructure

- Describe how the provider infrastructure will meet the 11 core functions as these are critical in assuring timely, comprehensive, and high-quality Health Homes services.
- In addition, states will need to address how their providers will adhere to the Health Homes service delivery system principles.

Review Document

11 Health Home Core Functions

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Delivery System Principals

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
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- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
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Types of Delivery Systems

- One service delivery system must be selected and more than one may be selected.
  - **Fee-For-Service**
  - Primary Care Case Management (PCCM)
  - **Risk-Based Managed Care**
  - Other Service Delivery System

If Risk Based Managed Care is selected, indicate *Yes* or *No* if the Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

- If *Yes* is selected (Health Plans will be a Designated Provider or part of a **Team of Health Care Professionals**):
  - Provide a summary of the contract language imposed on the Health Plans in order to deliver Health Homes services
  - Check the assurance, "The state provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review."
  - At your option, upload a copy of the Health Plan contract.
  - Select *Yes* or *No* whether Health Homes payments will be included in the Health Plan capitation rate.
    - **If *Yes* is selected, check the three assurances displayed.**
    - If *No* is selected, select one or more of the options to indicate which payment methodology(ies) will be used to pay the Health Plans:
      - Fee-for-Service methodology that is described in the Payment Methodologies screen
      - Alternative Model of Payment that is described in the Payment Methodologies screen
      - Other payment methodology. If Other is selected, describe the payment methodology

Payment Methodologies

Payment Methodologies

Select one or more of the following payment methodologies it will use to reimburse for Health Homes services:

- **Fee-for-Service**
- PCCM
- **Risk-Based Managed Care**
- Alternative models of payment

If Fee-for-Service is selected:

- Select one or more of the following options to describe how the payments are structured:
  - Individual rates per service
  - **Per member, per month rates**
  - Comprehensive methodology included in the plan
  - Incentive payment reimbursement

Next select one or more of the following options to describe the basis of the rates:

- **Severity of each individual's chronic conditions**
- Capabilities of the team of health care professionals, designated provider, or health team
- Other

If Risk Based Managed Care is selected, no further description is needed.

Rates and Rate Development

If Fee for Service was selected as a payment methodology, the Agency Rates section must be completed. Select one option which best describes the rates used from the following:

- FFS rates included in the plan
- Comprehensive methodology included in the plan
- The agency rates are set as of the following date and are effective for services provided on or after that date.
  - If this is selected:
    - Enter the effective date
    - Enter the website where the rates are displayed

If Fee for Service was selected as a payment methodology, the Rate Development section must be completed. Provide a comprehensive description of the manner in which rates were set, which must include:

- Cost data and assumptions used to develop each of the rates
- Reimbursable units of service
- Minimum level of activities required for providers to receive payment per the defined unit
- Standards and process required for service documentation
- Procedures for reviewing and rebasing the rates, including:
  - Frequency of review
  - Factors that will be reviewed in order to understand if the rates are economic, efficient and sufficient to ensure quality services.

Assure Non-Duplication of Payment

The manner in which the state will identify health homes services to ensure that there will be no duplication of services and payment for similar services provided under other Medicaid authorities, including whether billing and payment is handled through MMIS and how the State will track billable services if claims are not submitted through the MMIS.

Monitoring, Quality Measurement, Evaluation

Monitoring

Savings resulting from improved coordination of care and chronic disease management, including data sources and measurement specifications

Savings associated with serving dual-eligibles, including if Medicare data was available to the state and used in calculating the estimate.

Quality Measurement and Evaluation

- Report on CMS Health Home Core Measures
- Identify measurable goals and quality measures for each goal
- Track avoidable hospital readmissions
- Submit cost savings methodology and results with CMS Core Measures.

Office of Inspector General

Findings

Deficiency	No. of Unallowable Payments[a]
Core health home services not documented	37
Integrated health home outreach services not documented	18
Diagnoses not documented	9
Enrollment with health home provider not documented	10
Documentation to support higher payments for intense integrated health home services not maintained	4
Integrated health home providers did not ensure that beneficiaries had full Medicaid benefits	2

[a] The total exceeds 62 because 12 payments related to more than 1 deficiency.

Inadequate Monitoring

- Improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received PMPM payments;
- Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive the higher IHH PMPM payments for intense IHH services, and educate providers on these requirements; and
- Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive IHH PMPM payments for outreach services and educate providers on these requirements.

Next Steps

- Integrated Health Home SPA Review
- Iowa Administrative Code Review